



**Department of Veterans Affairs
Office of Inspector General**

Office of Healthcare Inspections

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Healthcare Inspection

Alleged Staffing, Quality of Care, and Administrative Deficiencies Amarillo VA Health Care System Amarillo, Texas

July 6, 2017

Washington, DC 20420

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Table of Contents

	Page
Executive Summary	i
Purpose	1
Background	1
Scope and Methodology	2
Inspection Results	5
Issue 1. Inadequate Nurse Staffing.....	5
Issue 2. Inadequate Physician Staffing	11
Issue 3. Physician Transfer Orders.....	13
Issue 4. Social Worker Home Visits	13
Issue 5. Veterans Crisis Line Follow-Up	14
Issue 6. Gastrointestinal Endoscopy Wait Times and Patient Lists.....	15
Issue 7. Discontinuation of Complex Surgeries	17
Conclusions	18
Recommendations	19
Appendixes	
A. Veterans Integrated Service Network Director Comments	20
B. Facility Director Comments.....	21
C. Office of Inspector General Contact and Staff Acknowledgments.....	26
D. Report Distribution.....	27

Executive Summary

The VA Office of Inspector General conducted a healthcare inspection to respond to a 2014 request from Congressman Mac Thornberry to assess the validity of allegations concerning inadequate staffing, quality of care, and administrative deficiencies at the Amarillo VA Health Care System (facility), Amarillo, TX. Specific allegations follow.

1. Due to inadequate nurse staffing:
 - a. In 2012 and 2013, three patient deaths occurred.
 - b. The facility has experienced an increase in patient falls. In 2012, one patient fell in the Emergency Department and sustained injuries.
 - c. The facility has experienced an increased number of patients with pressure ulcers.
 - d. The facility closed inpatient beds because they lacked staff to care for inpatients.
 - e. The facility has had to divert patients to non-VA facilities.
2. Due to inadequate physician staffing:
 - a. Local Emergency Medical Services have been instructed not to bring patients to the facility if they show signs of heart attack or stroke because the facility does not have enough physicians to provide care for these patients.
 - b. Home Based Primary Care and Home Telehealth patients' diagnoses were inappropriately changed from Chronic Obstructive Pulmonary disease to anything but a respiratory condition because the facility lacked a pulmonologist on staff.
3. The Chief Nurse Executive overrides physician transfer orders in the intensive care unit, which has placed many patients at risk.
4. Mental health social workers did not make required weekly visits for three high-intensity patients.
5. In 2013, a patient called the Veterans Crisis Line requesting to be seen and by 3 months later, had not been seen. He subsequently tried to kill himself. He was not seen by the facility.
6. The Gastrointestinal Endoscopy Clinic has a backlog and places patients on a paper list. Many patients have been on the list for over 150 days. Staff have changed documentation and shredded paper lists.
7. The facility no longer performs complex surgeries, so patients are referred to private hospitals for these surgeries at their own cost.

We substantiated that nurse staffing at the facility had not been optimal for several years, but we could not substantiate that inadequate nurse staffing resulted in the death of three patients, an increase in patient falls, or an increase in pressure ulcers. While reviewing the patient deaths, we identified an issue involving the quality of care provided by a specific nurse. We discussed the issue with facility leaders who took action. While reviewing pressure ulcer data, we identified the facility Pressure Ulcer Committee members did not consistently attend meetings, and that committee documentation did not include the development, implementation, monitoring, and evaluation of pressure ulcer prevention across the continuum of care.

We did not substantiate that the facility closed inpatient beds. We identified a time frame in FY 2012–2013 when the facility “closed” a unit during renovation. However, the facility increased capacity on a second unit during the renovation and the total number of beds was not decreased. We substantiated that the facility diverted patients to non-VA facilities in accordance with its diversion policy; however, our review of facility diversion data revealed administrative errors in the records. We found that facility staff failed to document notification of local Emergency Medical Services (EMS) about the diversion status, and facility leaders did not review diversion data quarterly or provide evidence of performance monitoring. When updating this information in 2016, we noted considerable improvement in the reporting of diversion data and notification of the local EMS.

We did not substantiate that low physician staffing was the basis for leadership’s decision to redirect certain EMS patients. We found that facility managers appropriately coordinated with local EMS to not bring heart attack or stroke patients to the facility because the facility did not have the specialty staff or equipment to provide specialized care for these types of patients.

We did not substantiate that patients’ diagnoses of Chronic Obstructive Pulmonary Disease were inappropriately changed to other diagnoses for patients enrolled in either the Home Based Primary Care or Home Telehealth programs because the facility did not have a pulmonologist on staff.

We did not substantiate the allegation that physician transfer orders were overridden by the Chief Nurse Executive.

We did not substantiate that mental health social workers failed to make required weekly visits for three high intensity patients. We also did not substantiate that in 2013, a patient called the Veterans Crisis Line requesting to be seen and by 3 months later, had not been seen at the facility.

We substantiated that the Gastrointestinal Endoscopy clinic had a procedure backlog due to construction in the endoscopy suite. We found that the facility lacked a process to track gastrointestinal endoscopy consults. We received updated information in October 2016, which confirmed that the Gastrointestinal Endoscopy staff had resolved the tracking issue and that consult notes were entered into the patient’s EHR, closed in the consult package, and tracked to completion.

We substantiated that the facility no longer performed complex surgeries. According to facility leadership, complex surgeries have not been performed at the facility since FY 2002. In FY 2011, the Veterans Health Administration designated the facility as having intermediate surgical capabilities. We could not substantiate that patients were referred to private hospitals for surgeries at their own expense.

We recommended that the Facility Director:

- Continue efforts to recruit and hire for nursing staff vacancies, and ensure that until optimal staffing is achieved, alternate methods are consistently available to meet patient care needs.
- Ensure members consistently attend Pressure Ulcer Committee meetings and document efficacy data on specific treatments, information on new treatment modalities, and action items, to include documentation of follow-up taken regarding action items.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided acceptable action plans. (See Appendixes A and B, pages 20–25 for the Directors' comments.) We will follow up on the planned actions until they are completed.



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Purpose

The VA Office of Inspector General (OIG) conducted a healthcare inspection to respond to a 2014 request from Congressman Mac Thornberry to assess the merit of allegations regarding inadequate staffing, quality of care, and administrative deficiencies at the Amarillo VA Health Care System (facility), Amarillo, TX.

Background

The facility is part of Veterans Integrated Service Network (VISN) 17¹ and provides care to veterans in the Texas and Oklahoma panhandle, eastern New Mexico, and southern Kansas. The facility has 30 general medicine/surgery, 14 intensive care unit (ICU), and 120 community living center (CLC) beds. The facility also provides health care to veterans residing in rural areas through four community based outpatient clinics (CBOC) located in Lubbock, Childress, and Dalhart, TX, and Clovis, NM.

In June 2014, Congressman Thornberry requested we evaluate complaints he received from a constituent. The complainant requested anonymity, and the complainant's name was not provided to us.² The complainant made the following allegations.

1. Due to inadequate nurse staffing:
 - a. In 2012 and 2013, three patient deaths occurred.
 - b. The facility has experienced an increase in patient falls. In 2012, one patient fell in the Emergency Department (ED) and sustained injuries.
 - c. The facility has experienced an increased number of patients with pressure ulcers.
 - d. The facility closed inpatient beds because they lacked staff to care for inpatients.
 - e. The facility has had to divert patients to non-VA facilities.
2. Due to inadequate physician staffing:
 - a. Local Emergency Medical Services (EMS) have been instructed not to bring patients to the facility if they show signs of heart attack or stroke because the facility does not have enough physicians to provide care for these patients.
 - b. Home Based Primary Care (HBPC) and Home Telehealth patients' diagnoses were inappropriately changed from Chronic Obstructive Pulmonary Disease

¹ In October 2015, VHA re-organized and Amarillo was moved from VISN 18 to VISN 17.

² The Facility Director also received a copy of the letter and was able to identify the specific cases referenced by the complainant. Facility leaders provided us with those patient names.

- (COPD) to anything but a respiratory condition because the facility lacked a pulmonologist on staff.
3. The Chief Nurse Executive (CNE) overrides physician transfer orders in the ICU, which puts many patients at risk.
 4. Mental health social workers did not make required weekly visits for three high-intensity patients.
 5. In 2013, a patient called the Veterans Crisis Line requesting to be seen and by 3 months later, had not been seen. He subsequently tried to kill himself. He was not seen by the facility.
 6. The Gastrointestinal (GI) Endoscopy clinic has a backlog and places patients on a paper list. Many patients have been on the list for over 150 days. Staff have changed documentation and shredded paper lists.
 7. The facility no longer performs complex surgeries, so patients are referred to private hospitals for these surgeries at their own cost.

Scope and Methodology

We conducted this review from August 2014 through October 2016. We conducted site visits August 4–8 and August 18–22, 2014; January 20–23, 2015; and March 23, 2016. We interviewed the former Director, two Acting Directors, the CNE, Chief of Staff, Chief of Medicine, Chief of Mental Health, Chief of Human Resources; the Director of Fee Basis; nurse managers from the CLC, medical/surgical unit, and the ICU; and other staff knowledgeable about the issues.

We reviewed documentation including Veterans Health Administration (VHA) and facility policies, hiring actions, and Strategic Analytics for Improvement and Learning (SAIL) staffing data, emergency medical transport service diversion data, pressure ulcer and falls data, non-VA medical care referrals, committee minutes, and quality management data.

We reviewed the electronic health records (EHR) of 3 patients alleged to have died due to decreased nurse staffing, 4 patients enrolled in the Mental Health Intensive Case Management Program (MHICM), 99 patients who underwent endoscopic procedures, 161 patients enrolled in HBPC,³ 47 patients in the Home Telehealth program,⁴ and 10 ICU patients. We received and evaluated additional CBOC-related allegations that

³ VHA Handbook 1141.01, *Home Based Primary Care Program*, January 31, 2007. This Handbook was scheduled for recertification by February 29, 2012, but has not yet been recertified. HBPC is comprehensive, longitudinal primary care provided by a physician-supervised interdisciplinary team of VA staff in the homes of veterans with complex, chronic, disabling disease for whom routine clinic-based care is not effective.

⁴ VHA *Home Telehealth Operations Manual*, April 15, 2013, “Home Telehealth is a program that applies care and case management principles to coordinate care using health informatics, disease management and Home Telehealth technologies to facilitate access to care and to improve the health of Veterans with the specific intent of providing the right care in the right place at the right time.”

will be addressed in a separate report. We received but did not address an allegation regarding a backlog of patient care appointments, as the complainant did not provide a specific time frame or specific clinic and we could not readily identify any backlogs to review.⁵ We also received but did not address personnel or labor relations concerns, as those issues were beyond the scope of our review.

Seven VHA policies cited in this report are expired or beyond the recertification date:

1. VHA Handbook 1141.01, *Home Based Primary Care Program*, January 31, 2007 (recertification due date February 28, 2012).
2. VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, July 19, 2010 (expired July 31, 2015).
3. VHA Handbook 1100.18 *Reporting and Responding to State Licensing Boards*, December 21, 2005 (recertification due date December 31, 2010).
4. VHA Handbook 1180.02, *Prevention of Pressure Ulcers*, July 1, 2011 (recertification due date July 31, 2016).
5. VHA Directive 2011-038, *Treatment of Acute Ischemic Stroke (AIS)*, November 2, 2011 (expired November 30, 2016).
6. VHA Directive 2010-018, *Facility Infrastructure Requirements to Perform Standard, Intermediate, or Complex Surgical Procedures*, May 6, 2010 (expired May 31, 2015).
7. VHA Handbook 1000.01, *Inpatient Bed Change Program and Procedures*, December 22, 2010 (recertification due date December 31, 2015).

We considered these policies to be in effect as they had not been superseded by more recent policy or guidance. In a June 29, 2016, memorandum to supplement policy provided by VHA Directive 6330(1),⁶ the VA Under Secretary for Health (USH) mandated the "...continued use of and adherence to VHA policy documents beyond their recertification date until the policy is rescinded, recertified, or superseded by a more recent policy or guidance."⁷ The USH also tasked the Principal Deputy Under Secretary for Health and Deputy Under Secretaries for Health with ensuring "...the timely rescission or recertification of policy documents over which their program offices have primary responsibility."⁸

⁵ We looked at Primary Care Clinics and CBOCs for possible appointment backlogs as those were the largest group of appointment slots at the facility; in August 2012, same and next day appointments were available.

⁶ VHA Directive 6330(1), *Controlled National Policy/Directives Management System*, June 24, 2016, amended January 11, 2017.

⁷ VA Under Secretary for Health Memorandum, *Validity of VHA Policy Document*, June 29, 2016.

⁸ Ibid.

We **substantiate** allegations when the facts and findings support that the alleged events or actions took place. We **do not substantiate** allegations when the facts show the allegations are unfounded. We **cannot substantiate** allegations when there is no conclusive evidence to either sustain or refute the allegation.

We conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Inspection Results

Allegation 1: Inadequate Nurse Staffing

Nurse Staffing

We substantiated that nurse staffing at the facility had not been optimal for several years. Interviews with nursing leadership revealed that the facility had been struggling to recruit and retain qualified nursing staff for several years prior to our review. We could not substantiate that inadequate nurse staffing resulted in the death of three patients.

The complainant specifically reported that “[s]ince 2011, nurse staffing has decreased to 20 percent, and the facility has lost more than 200 nurses since 2012 with most of the vacated positions not being filled.” We did not substantiate that facility nurse staffing decreased to 20 percent or that the facility lost more than 200 nurses. VHA data shows that between December 2011 and December 2013 the facility lost 8 registered nurses (RN) and 5 licensed vocational nurses (LVN). From December 2013 through December 2016, the facility added 44 RNs and 5 LVNs. Nursing leadership confirmed that in FYs 2011 and 2012, the facility had a budget shortfall, and through attrition, the facility decreased the number of staff. According to VHA SAIL data in FYs 2011 and 2012, the facility had a high turnover rate and ranked among the poorest in VHA medical facilities for nursing turnover rates. The facility has taken action since 2012 to improve the nursing turnover rate including increased nursing salaries, 36-hour work weeks, collaborative scheduling, and the number of incentive awards available. SAIL data from FY 2016 also showed a slight improvement in nursing turnover rate from FY 2015.

Nurse Staffing Methodology

VHA developed a nurse staffing methodology that states, “Staffing needs are individualized to specific clinical settings and cannot rely solely on ranges and fixed staffing models, staff-to-patient ratios, or prescribed patient formulas.”⁹ “The nurse staffing methodology also outlined a multi-step process designed to lead to a projection of how many full-time equivalent employees would be required for safe and effective care across all inpatient units. These projections were intended to develop appropriate budgets for each facility.”¹⁰

As described in VHA’s *Staffing Methodology for VHA Nursing Personnel* Guidebook,¹¹ the methodology calculates nursing hours accumulated during a 24-hour period and

⁹ VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, July 19, 2010. This Directive expired July 31, 2015, and has not been updated.

¹⁰ Taylor, B, et al. Evaluating the Veterans Health Administration's staffing methodology model: a reliable approach. *Nurs Econ.* 2015;33(1):36–40.

¹¹ VA Office of Nursing Services, *Staffing Methodology for VHA Nursing Personnel: GUIDEBOOK*, March 31, 2011.

distributes those hours over the number of patients present at one moment in time, 11:59 p.m. (the midnight census). The midnight census does not reflect the impact of fluctuations caused by new admissions, transfers, or discharges that occur prior to 11:59 p.m. Because daily Nursing Hours per Patient Day (NHPPD) is relative to the midnight census and data are thus not available for individual shifts during that day, it does not reflect variations in staffing levels that may have occurred earlier in the day.¹²

Patient Deaths

We could not substantiate that inadequate nurse staffing resulted in the deaths of three patients.

We reviewed daily NHPPD documentation on dates prior to the deaths of the three identified patients. We compared that data with the facility-recommended minimum targets to determine whether inadequate staffing may have contributed to the three patient deaths (one of the three patients also suffered falls—see Patient 1 below) and the presence of identifiable trends. However, because the midnight census value is used to calculate the NHPPD as described above, we could not assess staffing levels for each nursing shift.

We requested the daily nursing assignment sheets for the dates of the patient deaths and patient 1's falls. We were unable to obtain the requested documents as facility managers are not required to keep daily nursing assignment sheets for more than 14 days; however, a nurse manager had some daily nursing assignment sheets for one unit (3N).¹³ Because all daily assignment sheets were not available and the NHPPD is calculated at midnight, we were unable to assess whether the units were adequately staffed at the time of the deaths.

Nursing leaders told us that they adjusted staffing by transferring nurses from other units, pulling from a float pool, or enacting mandatory overtime. The effects of these adjustments were not always observable because the NHPPD was recorded at 11:59 p.m.

Patient 1 was in her early nineties at the time of her death with a history of dementia, syncopal episodes and difficulty with ambulation. The patient was admitted to the facility in 2013. Early in her stay, she was identified as a fall risk. Staff documented appropriate actions to reduce her fall risk in the EHR. However, she sustained two falls; one on Day 1 post admission, and the second fall on Day 3 post admission, which resulted in a hip fracture. The facility's calculated nurse staffing levels met the recommended target level on Day 1 post admission and exceeded the target level on Day 3 post admission. The patient eventually underwent surgery to repair the fracture

¹² Evan Fieldston, Meera Ragavan, Bhuvanewari Jayaraman, Joshua Metlay, Susmita Pati. Traditional measures of hospital utilization may not accurately reflect dynamic patient demand: findings from a children's hospital. *Hospital Pediatrics* 2012 Jan; 2(1):8–10.

¹³ Department of Veterans Affairs, *Record Control Schedule 10-1*, February 14, 2002 Veterans Health Administration (revised January 3, 2006 to include changes published after February 14, 2002).

(surgery was delayed because of complications related to the patient's cardiac disease). The EHR reflects that the patient received appropriate intra-operative and post-operative care. A week after surgery, the patient's condition deteriorated and her family requested hospice care. The patient died 6 days later.

Nursing assessed the patient according to the fall risk program and took appropriate measures. Nurse staffing met or exceeded the recommended target levels for the 24-hour period in which the fall occurred; EHR entries documenting the response, evaluation, and treatment of the patient following each fall do not suggest that nurse staffing levels compromised this patient's care.

Patient 2 was a male in his early nineties at the time of his death. In 2013, the patient was admitted from the CLC to the facility's ICU and treated for aspiration pneumonia. Several days later, his oxygenation and blood pressure stabilized, and a speech pathologist recommended a pureed diet with "maximum assist/aspiration precautions."¹⁴ The patient was transferred to a medical unit where a nurse supervised the patient eat "50 percent of his meal." The nurse documented that she then left the room, a family member was in the room, the patient's bed was elevated to "90 degrees," and 3 minutes later when she returned, the patient was in distress. The patient was transferred back to the ICU. As his condition deteriorated, his family requested comfort care measures only consistent with his DNR/DNI (do not resuscitate/do not intubate) orders, and the patient died the following day.

The medical/surgical unit NHPPD met target levels the day the patient was transferred to the medical unit. Appropriate precautions were documented relating to his diet, and the patient was supervised during the initial feeding. Nurse staffing did not appear to be an issue in this case.

Patient 3 was a male in his mid-seventies at the time of his death. In 2012, the patient presented to the facility's ED with hypotension and rapid breathing and was admitted to the telemetry unit.¹⁵ Several days after admission, the patient was given a medication for insomnia. Shortly before midnight, the patient was found to be at the foot of his bed without clothing, disconnected from all monitors, and disoriented to place. The bedside nurse documented that she attended to the patient, activated the bed alarm, and completed an "Adverse Reaction" entry in the EHR for the medication, citing confusion and disorientation. In addition, the bedside nurse noted that the patient was cyanotic and that she put oxygen tubing back on the patient. We found no evidence in the EHR that the patient's vital signs were reassessed at that time or that the bedside nurse notified the provider of the patient's behavior. Approximately 1 hour later, the telemetry nurse documented that the patient was "frequently off tele[m]etry, freq[uent] calls placed

¹⁴ Aspiration precautions are measures taken to prevent a person from aspirating or choking.

¹⁵ A telemetry monitor is a device that continuously transmits the patient's cardiac activity through external electrodes placed on the patient's body to a remote location, typically a centralized station on a nursing unit. Telemetry staff monitor the heart rate and rhythms from the remote location and notify staff who are in charge of the patient's care at the bedside (bedside nurse) if/when an abnormal heart rhythm occurs.

during shift informing leads off.” Approximately 30 minutes later, a resident physician entered a “Summary of Death Note” after responding to a Code Blue.

On the day preceding and up to the time of the patient’s death, the unit’s calculated nurse staffing level met the recommended target level. While deficient nurse staffing did not appear to be an issue in this case, the facility determined that the patient’s bedside nurse did not appropriately assess the patient after finding him cyanotic and failed to initiate cardiopulmonary resuscitation despite the patient being a “FULL CODE.” The nurse left employment at the facility shortly after the event.

We noted facility leaders had determined that Texas State Board of Nursing should be notified of this case in accordance with VHA policy; however, notification had not occurred at the time of our January 20–23, 2015, site visit.¹⁶ On May 16, 2016, VISN staff reviewed the reporting documents and returned the file to the facility and General Counsel for approval to send to the Texas State Board of Nursing. According to facility leadership, the Director signed the documents at that time and they were forwarded to the State board.

Patient Falls

We could not substantiate that on a specific date in 2012, a patient fell in the ED due to low staffing and sustained injuries. The complainant did not provide the patient’s name. We requested incident reports of all falls that occurred on the date the complainant provided. However, facility staff informed us that no falls had been reported for this date. We requested and reviewed the falls-related Root Cause Analyses for 2012, and none of the five reports occurred on the date that the complainant provided.

The facility had a process to monitor falls, and the data was reported to the Executive Leadership Board. The complainant reported, and we confirmed, a high number of falls during FY 2013 compared to subsequent years at this facility. VHA defines falls as “any change in elevation.” Although falls had occurred, no patients sustained major injuries.¹⁷ Upon comparing the fall rates for the first quarters of FY 2013 with FY 2016, we noted an overall improvement.

Pressure Ulcers

We did not substantiate that an increased number of patients developed pressure ulcers. The complainant did not provide details such as patient names, unit locations, or date ranges for the allegation. Because of the lack of specific dates, we requested Pressure Ulcer Committee meeting minutes for August 2014 through January 2015, the

¹⁶ According to VHA Handbook 1100.18 *Reporting and Responding to State Licensing Boards*, December 21, 2005, the facility is required to “report on their own initiative each licensed health care professional whose behavior or clinical practice so substantially failed to meet generally-accepted standards of clinical practice as to raise reasonable concern for the safety of patients.” This VHA Handbook was scheduled for revision or recertification on or before the last working day of December 2010 but has not yet been updated or recertified.

¹⁷ A major fall is when there are significant injuries.

6 months prior to the allegation. We received and reviewed 5 months of meeting minutes and facility pressure ulcer data for FY 2014 to January 2015. We did not find concerning trends in the reported occurrence of hospital acquired pressure ulcers.

While we did not identify concerning trends in the occurrence of hospital acquired pressure ulcers, we found deficiencies in the Pressure Ulcer Committee minutes. Per VHA policy, the Pressure Ulcer Committee should include representatives from multiple clinical disciplines across the continuum of care.¹⁸ However, we could not determine which facility staff members were assigned and/or present at each of the committee meetings due to the method of recording attendance. Further, the policy states that the Pressure Ulcer Committee is responsible for monitoring and evaluating a program for pressure ulcer prevention across the continuum of care, including the monitoring of data relevant to pressure ulcer prevention¹⁹. While the committee members were monitoring the data, we found limited documentation in the meeting minutes regarding the availability of certain treatments, efficacy data on specific treatments, information on new treatment modalities, staff education, identification of action items, and follow-up.

We reviewed hospital acquired pressure ulcer data for the first 3 quarters of FY 2016 and again did not identify concerning trends in the data. We also reviewed committee minutes from March through September 2016 and found improvement in documentation regarding staff education and EHR documentation regarding pressure ulcers. We also found that the Pressure Ulcer Committee included representatives from multiple clinical disciplines but noted inconsistent attendance at meetings. Deficiencies remained in documentation regarding:

- Availability of certain treatments
- Efficacy data on specific treatments
- Information on new treatment modalities
- Identification of action items and documentation of follow-up regarding action items

Alleged Closure of Inpatient Beds

We did not substantiate that the facility closed inpatient beds. We identified a time frame in FY 2012-2013 when the facility “closed” a unit during renovation. However, the facility increased capacity on a second unit during the renovation and the total number of beds was not decreased.

¹⁸ VHA Handbook 1180.02, *Prevention of Pressure Ulcers*, July 1, 2011. This VHA Handbook was scheduled for recertification on or before the last working day of July 2016 and has not yet been recertified.

¹⁹ VHA Handbook 1180.02.

VHA policy requires facilities submit a request to make beds “unavailable” during construction projects.²⁰ However, beds were not unavailable during this construction project as the facility was able to increase bed capacity on an adjacent unit. Private rooms on the adjacent unit were converted to semi-private ones. While the “closing” of the unit during renovation may have given the appearance of an official closing of beds, the number of beds was not decreased and the facility was not required to submit a request to VA National Bed Control System.²¹

Diversion to Non-VA Facilities

We substantiated that facility leadership diverted patients to other health care facilities for reasons that included staffing and bed availability. We noted, however, that VHA allows diversion as an approach to provide safe, quality care for patients.²² VHA policy states that a facility can divert patients coming to the facility via ambulance from other health care facilities when the appropriate care, services, or beds are not available; staffing is inadequate; or a disaster disrupts normal operations.²³

We reviewed diversion data from September 2012 through August 2014 and determined that the facility did not comply with VHA or facility policy as follows:

- VHA policy requires tracking of facility data related to the frequency, total time on diversion, and indications for diversion.²⁴ We found multiple entries for the same time periods made by different individuals. These duplicate entries were inconsistent with the specific time frame, in-hospital location (ICU only or total facility), staffing, patient acuity, bed status, and patient census. Some entries showed diversion beginning and ending on the same date and time, resulting in diversion duration of 0 (zero) minutes. While this likely had the effect of overstating the incidences of diversion, the improper record-keeping makes it impossible to determine accurate data relating to diversions.

²⁰ VHA Handbook 1000.01, *Inpatient Bed Change Program and Procedures*, December 22, 2010. This Handbook was scheduled for recertification on or before the last working day of December 2015 and has not yet been recertified.

²¹ Ibid.

²² VHA Directive 2009-069, *VHA Medical Facility Emergency Department Diversion Policy*, December 16, 2009. This Directive was current at the time of the events discussed in this report; it has been rescinded and replaced by VHA Directive 1101.05(1), *Emergency Medicine*, September 2, 2016, amended October 27, 2016. The 2016 Directive provides more specific definitions of diversion and requirements for documenting time frames of diversion.

²³ Ibid.

²⁴ According to VHA Directive 2009-069, *VHA Medical Facility Emergency Department Diversion Policy*, December 16, 2009, “The Chief of Staff, or designee, is responsible for designating an individual to maintain data in the diversion tracking data base and ensuring that these data are reviewed on an ongoing basis. Data collected must include: (a) exact reason for diversion. (b) number of hours the ED and medical facility is on diversion.”

- VHA policy requires facilities to review diversion data on a quarterly basis as part of the performance monitoring and improvement process.²⁵ While facility policy²⁶ designated leaders with responsibility for monitoring and reporting diversion data, we found that data were not monitored and reported quarterly to an executive committee responsible for performance monitoring and improvement. Facility leaders could not provide evidence of performance monitoring, and staff members who recorded diversion status were unaware of the reporting requirement. Additionally, none of the leaders with designated responsibility for reviewing the data detected the data errors described above.
- Facility policy requires that the Bed Control/Admissions Case Manager notifies local EMS about the facility diversion status. The notification should include the specific length of time for diversion status (for example, 4, 8, 12 hours) and the extension or termination of the diversion status. Facility leaders told us that they notified the local EMS staff; however, they were unable to provide us documentation as they did not retain the records of notification.²⁷

In October 2016 we re-reviewed the facility's process for recording and monitoring diversion and found the following improvements:

- Discussion of diversion data in the monthly executive level Quality, Safety and Value committee
- Maintenance of a single Administrative Officer of the Day spreadsheet to track use of diversion and when diversion occurs
- Documentation of diversion occurrences in the Bed Management System²⁸
- Discussion of diversion data daily at the morning huddles
- Documentation of notification of the local EMS in the Administrative Officer of the Day report

Allegation 2. Inadequate Physician Staffing

Heart Attack and Stroke Care

We did not substantiate that inadequate physician staffing was the basis for facility leadership's decision to redirect certain EMS patients. We found that local EMS staff had been instructed not to bring patients to the facility if patients showed signs of heart attack or stroke because the facility did not have the required specialized staff and equipment to care for these types of patients. Facility leadership made this intentional

²⁵ According to VHA Directive 2009-069, "The facility Director is responsible for ensuring that accurate tracking of the frequency, total time on diversion, and reasons for diversion occur. These data must be reviewed on a quarterly basis as part of the performance monitoring and improvement process."

²⁶ Medical Center Memorandum #ARS-05-0511, *Ambulance Diversion Guidelines*, May 13, 2011.

²⁷ Ibid.

²⁸ The Bed Management System is a computer program utilized to track facility open beds.

and appropriate decision to ensure that patients received care in facilities better equipped to manage their needs. If patients arrived at the facility while experiencing a stroke or heart attack, staff stabilized the patients and transferred them to local hospitals where their needs could be met.

VHA policy states that a facility can divert incoming patients to other health care facilities when the appropriate care, services, or beds are not available.^{29,30} The former facility Director and former Chief of Staff confirmed that patients who showed signs of heart attack or stroke were diverted to a community facility with the capability of providing specialized care.

Pulmonary Care

We did not substantiate that COPD diagnoses for the 161 patients enrolled in HBPC and for the 47 patients enrolled in Home Telehealth programs in April 2014 (6 months prior to the time corresponding to the complaint) were changed to other diagnoses because the facility did not have a pulmonologist on staff to care for these patients.

VHA provides services through HBPC and Home Telehealth for patients with complex chronic medical conditions such as COPD, congestive heart failure, asthma, and heart disease. Practitioners enter diagnoses onto the patient's Problem List in the EHR, the current date is automatically attached and the practitioner completes the record with an electronic signature. "No edit, reassignment, deletion, or alteration of any documentation after the manual or electronic signature has been completed can occur without the approval of the Health Information Management (HIM) professional or the Privacy Officer."³¹

We reviewed the EHRs of the 161 patients enrolled in HBPC and 47 patients enrolled in Home Telehealth as of April 2014; 75 patients had a documented diagnosis of COPD and were excluded from further review. The remaining 133 patients had chronic conditions that may have necessitated the use of supplemental oxygen and/or medications, such as inhalers, to alleviate their symptoms. We focused our review on problem lists, medication lists, pulmonary consultations, supplemental oxygen orders, and other clinical indicators that might suggest an underlying diagnosis of COPD. We compared patients' previous diagnoses with diagnoses present at the time of our review and found no evidence of altered diagnoses of COPD.

²⁹ VHA Directive 2009-069.

³⁰ VHA Directive 2011-038, *Treatment of Acute Ischemic Stroke (AIS)*, November 2, 2011. This Directive expired November 30, 2016, and has not yet been updated.

³¹ VHA Directive 1907.01 *Health Information Management and Health Records*, September 19, 2012. This Directive was rescinded and replaced in 2014 and 2015. The subsequent Directives contained the same or similar statements.

Patients with COPD are routinely managed by primary care providers as long as their conditions are stable.³² Primary care providers have the option to refer patients to pulmonologists for complex respiratory issues. We confirmed that the facility did not have a pulmonologist on staff in 2014 and 2015. If a patient needed to see a pulmonologist, regardless of whether they had a diagnosis of COPD or not, they were referred to a non-VA facility.

Allegation 3. Physician Transfer Orders

We did not substantiate that the CNE overrode physician orders to retain patients in the ICU, thereby placing patients at risk. The facility ICU Nurse Manager told us that a Utilization Management nurse reviewed all ICU patients using the National Utilization Management Integration model to determine the acuity level of illness, which in turn, determined the appropriateness for ICU level of care.³³

We interviewed the former Facility Director who stated that the CNE met every morning with the nursing supervisors to get a report of events that occurred during the previous 24 hours. If a Utilization Management (UM) nurse deemed that ICU level of care was no longer appropriate for a patient and did not have a physician ICU transfer order, the CNE requested a reason for the delayed transfer and coordinated with a physician to facilitate the transfer. The ICU Nurse Manager reported that patients would not leave the unit without a physician's written order. We reviewed 10 of 46 EHRs of ICU patients who were transferred out of the ICU to another unit during selected quarters in FYs 2013, 2014, and 2015, and found that physician orders were written for each transfer.

Allegation 4. Social Worker Home Visits

We did not substantiate that mental health social workers were not making required weekly home visits for three high-intensity (MHICM) patients in 2013. In the MHICM program, an interdisciplinary team provides treatment interventions to seriously mentally ill patients living in community settings. During the time frame at issue, neither VHA or facility policy required weekly social worker visits. Instead, VHA required that an MHICM team member have contact 2–3 times weekly during the intensive (first year)

³² VA/DoD *Clinical Practice Guideline for the Management of Chronic Obstructive Pulmonary Disease*, Version 3.0, December 2014.

³³ According to VHA Directive 2010-021, *Utilization Management Program*, May 14, 2010. “The UM reviewer is the trained, licensed health care professional who performs UM reviews utilizing the National Utilization Management Advisory Committee (NUMAC)-approved, standardized, evidence-based criteria. A concurrent review is performed during a patient's hospital stay, or course of treatment, to screen for the appropriateness of the medical services.” This Directive was current at the time of the events discussed in this report; it was rescinded and replaced by VHA Directive 1117, *Utilization Management Program*, July 9, 2014 that has the same or similar definition.

phase of case management.³⁴ Facility policy required frequent encounters, “typically consisting of at least 1 weekly face-to-face meeting with an MHICM staff member”³⁵ and assigned responsibility for the encounters to registered nurses and social workers.

The complainant provided a date and the first letter of three patients’ last names. Facility leadership reviewed the complainant’s list against the MHICM patient roster and readily identified 2 of the 3 patients. The third patient’s last name began with the letter B. The facility’s roster listed two patients whose last names began with the letter B. Because we could not identify which of those patients was the third patient at issue, we reviewed both patients for a total of four patients. We found that all four patients were visited by a mental health professional consistently and regularly, based on their clinical needs and consistent with their treatment plan. The allegations of missed visits were not supported by the patients’ records, which reflected multiple visits within the date ranges alleged.

Allegation 5. Veterans Crisis Line Follow-Up

We did not substantiate that in 2013, a patient called the Veterans Crisis Line (VCL) requesting to be seen by a mental health provider and by 3 months later, was not seen and later tried to commit suicide.

The complainant provided a date and the first letter of the patient’s last name, and leadership was able to identify the patient. The patient was enrolled in the MHICM program and was receiving frequent visits from MHICM team members. We reviewed the patient’s EHR and found that the patient called the VCL in 2013. The patient stated that he was not suicidal at the time of the call. He was contacted by MHICM staff the same day of the VCL call. He was hospitalized at the facility approximately 2 weeks after the VCL call for a medical condition and continued to receive visits and other contacts from MHICM staff after release from the hospital. We did not find documentation in the EHR that the patient attempted suicide in the cited time frame.

³⁴ VHA Directive 2006-0004 *VHA Mental Health Case Management*, January 30, 2006. This program provides a “High intensity of care (typically two to three contacts per week) primarily through home and community visits... After one year of MHICM treatment, some veteran clients can be transferred to either standard care or to continuous treatment by the MHICM team at a lower level of intensity (e.g., typically requiring community contacts less than once per week).” This Directive was rescinded and replaced with VHA Handbook 1163.06 *Intensive Community Mental Health Recovery Services*, January 7, 2016 and contains the same or similar language regarding frequency of contacts.

³⁵ Amarillo Mental Health Policy and Procedure #14, *Mental Health Intensive Case Management Program (MHCIM) Rural Access Network for Growth Enhancement (RANGE)*, July 1, 2013 “High intensity care will typically consist of at least one weekly face to face meeting with a MHICM clinical staff member.” This policy has been revised and updated on an annual basis. The 2015 version states: “Contact will be frequent, based on the clinical discretion of the MHICM leader taking into account the clinical needs of a Veteran at a given period of their care, the Veteran’s wishes and desires about frequency of contact, and the Veteran’s recent level of psychiatric and psychosocial stability.”

Allegation 6. GI Endoscopy Wait Times and Patient Lists

Wait Times: Backlog in January 2014

We substantiated that the GI Endoscopy clinic had a backlog of patients waiting for procedures during a specific time frame in January 2014. However, we did not substantiate that patients waited over 150 days for procedures.

The complainant did not provide a time frame for the alleged patient backlog. Facility leaders told us that the endoscopy suite was under construction in January 2014, making the procedure rooms temporarily unavailable. During this time, clinic staff performed endoscopies in procedure rooms shared with the Surgical Service. This limited the number of endoscopy procedures that the Gastroenterology Service could perform. We therefore focused our review on this time frame.

In the absence of facility consult timeliness data, we identified 145 GI endoscopy consult³⁶ requests for screening, surveillance, or diagnostic procedures in January 2014 when the clinic had a backlog due to construction. We excluded 47 consults not scheduled at the facility and reviewed the remaining 98 consults.

The facility expectation was that screening colonoscopies^{37,38} would be completed within 90 days of the date the consult was ordered.³⁹ We found:

- 13 of the 27 screening colonoscopies were completed within the 90-day time frame;
- 14 of the 27 screening colonoscopies were not completed within the 90-day time frame because of a delay in scheduling.⁴⁰

The remaining 71 endoscopies were to be scheduled according to the referring provider's instructions.⁴¹

³⁶ In this report, we use the term endoscopy to describe screening and diagnostic colonoscopies, and esophagogastroduodenoscopies.

³⁷ Screening colonoscopies were done in lieu of Fecal Occult Blood Test or Fecal Immunochemical Test (stool sampling) in patients who were considered average risk for cancer.

³⁸ VHA Directive 2007-004, *Colorectal Cancer Screening*, January 12, 2007. This Directive was replaced with VHA Directive 1015, *Colorectal Cancer Screening*, December 12, 2014. The VHA Directives did not have a requirement that a screening colonoscopy be completed within 90 days of the date the consult was ordered.

³⁹ Medical Center Memorandum 11C-02-0214, *Consult Processing*, February 7, 2014. "Consult package should be used for requesting actions when the expectation is that the work will be completed within 90 days." The patient population included patients referred for screening colonoscopies during January 2014. The policy, published in February of 2014, formalized the facility's practice.

⁴⁰ Procedures that were referred to non-VA providers or declined by the service due to clinical conditions of the patient were excluded from review.

- 6 of the remaining 71 endoscopies were either cancelled prior to the dates of the procedures or the patients did not present for scheduled procedures.
- 18 of the remaining completed 64 endoscopies were delayed.

None of the patients who experienced scheduling delays had adverse clinical outcomes related to the delays.

Wait Times: Inability to Track

During our inspection, we found that the facility lacked processes that allowed the tracking of GI endoscopy consults.⁴² Facility staff had assigned the GI Endoscopy clinic a stop code, (a numeric designation used to track and schedule appointments and consults),⁴³ that was also assigned to other clinics. Therefore, we could not use the facility's data to determine wait times specific to the GI Endoscopy clinic. We also determined the facility's consult tracking report may have reflected an inaccurate number of open consults.

VHA identified deficiencies related to consult management in 2012 and provided guidance to facilities that included assigning clinic stop codes and completing a consult in the patient's EHR.⁴⁴ ⁴⁵ Without the proper stop code, the consult was not linked to the appointment clinic. If the consulting clinician did not properly enter a note in the patient's EHR (thereby linking the request to the consultant's note), the consult would appear open in the tracking report even though care had been rendered.⁴⁶ ⁴⁷

We found the GI Endoscopy clinic process omitted linking a physician's written progress note to complete the consult. Therefore, the consult was not closed in the consult package and thus facility leaders were unable to track the time to completion.

In 2015, the facility GI Endoscopy clinic staff conducted an internal review of GI endoscopy consults for timeliness of completion, followed up with patients whose procedures were not completed, and assigned a unique stop code to the clinic to enable workload data, including scheduling delays, to be tracked. Based on updated

⁴¹ VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, June 9, 2010. This Directive was current at the time of the events discussed in this report; it was rescinded and replaced by VHA Directive 1230, *VHA Outpatient Scheduling Processes and Procedures*, July 15, 2016.

⁴² Per VHA Directive 2008-056, *VHA Consult Policy*, dated September 16, 2008. A consult is a specific document, most often electronic, which facilitates and communicates consultative and non-consultative service requests and subsequent activities.

⁴³ VHA Directive 1731, *Decision Support System Outpatient Identifiers*, May 29, 2013.

⁴⁴ VHA, *Consult/Request Tracking User Manual*, Version 3.0, June 2014.

⁴⁵ Medical Center Memorandum 11C-02-0214, *Consult Processing*, dated February 7, 2014. "Consult package should be used for requesting actions when the expectation is that the work will be completed within 90 days.

⁴⁶ See VAOIG *Evaluation of the Veterans Health Administration National Consult Delay Review and Associated Fact Sheet*. (Report No. 14-04705-62. December 15, 2014).

⁴⁷ Medical Center Memorandum 11C-02-0214, *Consult Processing*, February 7, 2014. "Consult package should be used for requesting actions when the expectation is that the work will be completed within 90 days."

information received in October 2016, we confirmed that GI Endoscopy clinic staff resolved the issue with the non-specific GI endoscopy stop code and that consult notes were being entered into the patient's EHR, closed in the consult package, and tracked to completion. As of October 6, 2016, only 8 of 712 endoscopies were not completed within 90 days of the clinically indicated date.

Paper Wait Lists

We did not substantiate that GI Endoscopy clinic staff used paper wait lists or that documentation was altered or destroyed inappropriately.⁴⁸

We did not find a paper wait list; however, we were told that a clinician in the GI Endoscopy clinic generated a copy of each day's scheduled patient report to confirm that procedures were performed as scheduled or to ensure that patients whose procedures were not performed received follow-up for rescheduling. Occasionally, procedures were not completed as scheduled for reasons beyond the facility's control; for example, the patient did not show up for the appointment, or the patient did not follow instructions for the required pre-procedure preparation and was rescheduled. The copy of the scheduled patient report was shredded weekly. This practice, if observed, could have been interpreted as a provider maintaining a paper wait list and/or destroying a list inappropriately.

Allegation 7. Discontinuation of Complex Surgeries

We substantiated that the facility was not performing complex surgeries; however, we found this to be within the facility's designation for surgical procedures it was allowed to offer based on resources and skill level of providers.⁴⁹ We could not substantiate the allegation that patients were referred to private (non-VA) hospitals for complex surgeries at their own expense.

Facility leadership told us that complex surgeries have not been performed at the facility since FY 2002. In FY 2010, VHA issued guidance that required each VA medical facility with an inpatient surgical program to have a surgical complexity designation of standard, intermediate, or complex based upon the facility infrastructure, and to ensure that scheduled (non-emergent) surgical procedures did not exceed the infrastructure

⁴⁸ See also VAOIG *Administrative Summary of Investigation by the VA OIG in Response to Allegations Regarding Patient Wait Times. Endoscopy Clinic Amarillo at the VA Medical Center Texas, Outpatient Clinic Lubbock at the VA Medical Center Texas*, (Report # 14-02890-152, March 8, 2016) wherein we determined that: "[t]he Endoscopy Clinic Amarillo was using paper records to ensure continuity of care and to track the tissues samples. Emails showed that management was aware of these paper records and they were destroyed in accordance with VA directives."

⁴⁹ VHA Directive 2010-018, *Facility Infrastructure Requirements to Perform Standard, Intermediate, or Complex Surgical Procedures*, May 6, 2010. Examples of what an Intermediate facility can do include amputation, mastectomy, and corneal transplant. This Directive expired May 31, 2015 and has not yet been updated.

capabilities of the facility.⁵⁰ In FY 2011, VHA classified the facility with an “intermediate” surgical capability.

The complainant did not provide a time frame or identify specific patients who were referred for surgery at their own expense. Facility policy stated that with pre-authorization, a patient may be referred to a non-VA health care provider at VA expense “...to enhance access to medical services, address the special needs of certain patients, or to provide services not available at the facility.”⁵¹ The facility had a comprehensive process in place to track patients who were in need of non-VA care, which contains information about care provided by non-VA health providers and payments made on behalf of patients for that care.

Conclusions

We substantiated that nurse staffing at the facility has not been optimal for several years, but we could not substantiate that inadequate nurse staffing resulted in the deaths of three patients, an increase in patient falls, or an increase in pressure ulcers. While reviewing the patient deaths we identified an issue involving the quality of care provided by a specific nurse. We discussed the issue with facility leaders who took action. While reviewing pressure ulcer data, we identified that facility Pressure Ulcer Committee members did not consistently attend meetings, and that committee documentation did not include the development, implementation, monitoring, and evaluation of pressure ulcer prevention across the continuum of care.

We substantiated that the facility diverted patients to non-VA facilities for reasons that included bed availability and staffing in accordance with its diversion policy. Although we substantiated the use of diversion, VHA allows diversion as an approach to provide safe, quality care for patients already admitted. We found that facility staff failed to document notification to local Emergency Medical Services (EMS) about the diversion status, that data about diversions was not properly logged, and that facility leaders did not review diversion data quarterly or provide evidence of performance monitoring. When updating this information in 2016, we noted considerable improvement in the reporting of diversion data and notification of the local EMS.

We did not substantiate that the facility closed inpatient beds. We identified a time frame in FY 2012–2013 when the facility “closed” a unit during renovation. However, the facility increased capacity on a second unit during the renovation and the total number of beds was not decreased.

⁵⁰ VHA Directive 2010-018, *Facility Infrastructure Requirements to Perform Standard, Intermediate, or Complex Surgical Procedures*, May 6, 2010. Examples of what an Intermediate facility can do include amputation, mastectomy, and corneal transplant. This Directive expired May 31, 2015 and has not yet been updated.

⁵¹ Medical Center Memorandum 136-13-0514, *Non-VA Care Coordination Referrals*, May 21, 2014. “With pre-authorization, a Veteran patient may be referred to a non-VA health care provider to enhance access to medical services, address the special needs of certain Veterans, or to provide services not available at the AVAHCS [facility].”

We did not substantiate that low physician staffing was the basis for facility leadership's decision to redirect certain EMS patients. We found that facility managers appropriately coordinated with local EMS to divert heart attack or stroke patients to other hospitals because the facility did not have the specialty staff or equipment to provide the specialized care for these patients.

We did not substantiate that patients' diagnoses of COPD were changed to other diagnoses for patients enrolled in HBPC and Home Telehealth programs because the facility did not have a pulmonologist on staff.

We did not substantiate that physician orders for patients to remain in the ICU were overridden by the CNE.

We did not substantiate that mental health social workers failed to make required weekly visits for three high intensity patients. We also did not substantiate the allegation that in 2013, a patient called the VCL requesting to be seen and by 3 months later, was not seen.

We substantiated that the GI Endoscopy clinic had extended wait times in early 2014 but the backlog had been resolved. We did not substantiate that clinic staff used paper wait lists or that documentation was altered or destroyed inappropriately.

We substantiated that the facility was not performing complex surgeries but that this was consistent with the facility's designation for surgical procedures; we could not substantiate that patients were referred to private (non-VA) hospitals for surgeries at their own expense.

Recommendations

1. We recommended that the Facility Director continue efforts to recruit and hire for nursing staff vacancies, and ensure that until optimal staffing is achieved, alternate methods are consistently available to meet patient care needs.
2. We recommended that the Facility Director ensure members consistently attend Pressure Ulcer Committee meetings and document efficacy data on specific treatments, information on new treatment modalities, and action items, to include documentation of follow-up taken regarding action items.

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: April 28, 2017

From: Director, VA Heart of Texas Health Care Network (10N17)

Subj: Healthcare Inspection—Alleged Staffing, Quality of Care, and Administrative Deficiencies, Amarillo VA Health Care System, Amarillo, Texas

To: Director, Washington DC Regional Office of Healthcare Inspections (54DC)
Director, Management Review Service (VHA 10E1D MRS Action)

1. Thank you for the opportunity to review and respond to the report, Healthcare Inspection – Alleged Staffing, Quality of Care, and Administrative Deficiencies, Amarillo VA Health Care System, Amarillo, Texas.
2. I have reviewed and concur with the recommendations in the report. If you have any questions or require further information, please contact Denise B. Elliott, Quality Management Officer for VISN 17 at 817-385-3734.

(original signed by Mark Doskocil, Deputy Network Director, for:)

Michael Kiefer, MHA, FACHE
Acting Network Director, VISN 17

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: April 27, 2017

From: Director, Amarillo VA Health Care System (504/00)

Subj: Healthcare Inspection—Alleged Staffing, Quality of Care, and Administrative Deficiencies, Amarillo VA Health Care System, Amarillo, Texas

To: Director, VA Heart of Texas Health Care Network (10N17)

1. Attached you will find the facility response to Recommendations 1 and 2 for the OIG report entitled, “Alleged Staffing, Quality of Care, and Administrative Deficiencies.” I have reviewed the findings, the recommendations, and the action plan and concur.
2. Should you have any questions, please contact Jinjer Mitchell, Acting Chief, Quality, Safety, Value Service at (806)355-9703 ext. 7772

(original signed by Louise Anderson, RN, MSN, for:)

Liz Lowery
Acting Director

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

Recommendation 1. We recommended that the Facility Director continue efforts to recruit and hire for nursing staff vacancies, and ensure that until optimal staffing is achieved, alternate methods are consistently available to meet patient care needs.

Concur

Target date for completion: All of these items have already been implemented and are in progress. This recommendation will be monitored on an ongoing basis through the SAIL quarterly report for RN Turnover and will be reported through the governance structure to leadership, and initiatives for improvement will continue indefinitely.

Facility response:

- For retention of nursing staff, the following has been implemented:
 - New and Existing Employee Focus Groups were utilized to gather information on opportunities for improvement from new nursing staff, as well as existing staff. (Completed, 4/2015).
 - Nursing staff are now able to utilize self-scheduling, in order to meet their individual scheduling needs. (Implemented 7/20/15).
 - The nursing orientation process and tools were re-organized and re-formatted to improve consistency and feed-back communication throughout the process. (Completed, start date of new process 8/2015).
 - Nursing staff are given entrance and exit surveys to learn opportunities for improvements to be made from the feedback given. (Ongoing via Nurse ADPAC with direct feedback to the ADPCS/NE for follow-up).
 - 30 -60-90 day "stay surveys" have been implemented for new nursing staff to assist management determine the progress of their orientation and intention to remain employed (implemented in the CLC April 2016 with composite of first 20 employees completed April 2017).
 - The Daisy Award program was implemented quarterly to increase recognition of excellent nursing care (implemented November 2016).
 - The preceptor program was revitalized to increase the number of available and trained preceptors. (Classes completed 9/2015).

- Our facility contacted other Level II VA Organizations with 4 & 5-Star ratings in SAIL to evaluate their processes and incorporate any best practices for retention. No new action items were noted.
- Management training was increased to include Leaders Developing Leaders, Right to Lead, and Just Culture. (All completed in FY 16 – NCOD 360 Servant Leadership Surveys Implement 2017.)
- Initial steps have been taken by leadership to pursue Pathways to Excellence Certification. (Recruiting for Coordinator for the program.)
- The platform of “Engage!” where employees have the opportunity either anonymously or identified to ask questions, voice concerns, and have rumors dispelled or confirmed through leadership has been implemented.
- Bi-annual Nursing Town Hall meetings have been implemented, as well as quarterly all employee Town Hall Meetings.
- For recruitment of nursing staff, the following has been implemented:
 - Our facility has strengthened and added nursing academic affiliations.
 - Our facility continues to participate in the VALOR program
 - The Upward Mobility program has been strengthened and developed more fully.
 - Leadership performed local salary surveys which resulted in increased salaries to compete with local market standards.(Effective date of pay scale changes was 4/3/16).
- Recently, nursing management developed a dashboard to begin monitoring gains, losses, vacancy rates, and turnover rate. A Facility Nursing Hours per Patient Day (NHPPD) dashboard has been developed, as well. These dashboards and data points are discussed and then reported up through the governance structure for oversight and action.
- Alternate means of meeting patient care needs have included:
 - A float pool has been developed and utilized to meet the various staffing needs.
 - Bed availability is adjusted based on staffing availability.
 - Development of a Surge Plan for periods of increased census
 - Pull staff from other units as appropriate

- Management calls unit staff rosters to bring in available staff on overtime
- Management request Voluntary OT/CTE of on-duty staff
- Mandatory OT for on-duty staff
- NM/ANM/NOD are assigned to provide direct patient care as needed during surge periods
- Use of other department's staff is utilized (within applicable scope of practice and competency)
- Management combines Med-Surg units (if censuses allows)
- There is a triage of patients for appropriate levels of care internally:
 - Triage for possible discharge or transfer to different level of care
 - Triage ICU, based on staff competency and patient acuity, adjust staffing requirements based on lower acuity such as when there are Med/Surg overflow patients
- Since the time of the allegations in this report the RN Turnover has improved from a rate of 11.58 in FY14 to a rate of 5.8 in FY17Q2.

Recommendation 2. We recommended that the Facility Director ensure members consistently attend Pressure Ulcer Committee meetings and document efficacy data on specific treatments, information on new treatment modalities, and action items, to include documentation of follow-up taken regarding action items.

Concur

Target date for completion: All action items will be implemented with the next Pressure Ulcer Committee meeting on May 2, 2017. This committee will report up through the governance structure to leadership for sustainability and accountability.

Facility response:

- The Pressure Ulcer Prevention Committee and facility will enforce the Governance MCM that outlines lack of attendance in the following way: Non-attendance of members is to be reported to the appropriate Board chair after missing two consecutive meetings. Committee meeting attendance will be discussed through the governance reporting structure to aid in accountability, as needed.
- The following items will be made standing agenda items for the Pressure Ulcer Prevention Committee meetings:

- Availability of certain treatments
 - Efficacy data on specific treatments
 - Information on new treatment modalities
 - Identification of action items and documentation of follow up regarding action items
- Since the time of allegations the Hospital Acquired Pressure Ulcer rate was 1.1% for FY14 and is 1% YTD FY17.

OIG Contact and Staff Acknowledgments

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